

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2013
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Dates of Survey: September 23, 24, 25, 26, &, 27, 2013</p> <p>Facility Number: 000367 Provider Number: 155458 AIM Number: 100289280</p> <p>Survey Team: Heather Tuttle, R.N. T.C. Caitlyn Doyle, R.N. Yolanda Love, R.N. Janelyn Kulik, R.N. (September 23, 2013)</p> <p>Census Bed Type: 34 SNF/NF 34 Total</p> <p>Census Payor Type: 10 Medicare 16 Medicaid 8 Other 34 Total</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality Review completed on October 4, 2013, by Jan Kulik, RN</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>				

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview, the facility failed to credit interest earned to resident personal funds accounts that were in excess of \$50.00 for 2 of 4 residents reviewed for personal funds. (#27 and #22)</p> <p>Review of the Residents' personal funds accounts on 9/27/13 at 12:00 p.m., indicated there were two residents for the month of August 2013 whose fund account was in excess of \$50.00 and should have received interest. The interest earned for the pooled account was \$0.12.</p> <p>Resident #27 had \$113.57 in the account and received no interest for August.</p> <p>Resident # 22 had \$89.61 in the account and received no interest for August.</p> <p>A list of the August accounts and interest paid, provided by the Business Office Manager, indicated resident #27 and resident #22</p>	F000159	F-159 What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #27 and #22 had interest applied to their account on 10/15/2013.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents who have more than \$50.00 in their account will be audited to ensure that all of these residents have interest applied to their account. This will be accomplished on 10/15/2013.What measures will be put into place or what systemic changes will be made to ensure that he deficient practice does not recur? A policy was written on 10/15/2013 in regards to resident trust and accounts and interest and business office manager was inserviced on 10/15/2013 on the policy.How the corrective actions will be monitored to ensure the deficient practice will not recur? An audit of all residents with more than \$50.00 in their account will be audited monthly for two month then quarterly to ensure the	10/27/2013

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	<p>received no interest for the month of August 2013.</p> <p>Interview with the Business Office Manager on 9/27/13 at 12:00 p.m., indicated she was unsure why some of the accounts were paid interest and others were not. She indicated the computer system used by the facility should calculate and apply interest to each account monthly, but for some reason had not applied interest to certain accounts.</p> <p>3.1-6(c)</p>		<p>deficient practice will not recur. This will be overseen by the quality assurance committee and the Health facility administrator. Completion date: 10/27/2013 Attachment #1 and #2</p>		

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F000174 SS=D	<p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY</p> <p>The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>Based on observation, record review and interview the facility failed to ensure each resident had access to the telephone related to a resident requesting to use the telephone and was denied by staff to do so for 1 of 1 residents reviewed for access to the telephone. (Resident #24)</p> <p>Findings include:</p> <p>Observation during Orientation Tour on 9/23/13 at 8:00 a.m., Resident #24 was observed in her wheelchair at the Nurse's Station. At that time the resident was requesting to use the telephone. RN #1 who was the midnight nurse, indicated to the resident that she could not make a phone call at the present time, "It was a busy time" and instructed the resident to wait until after breakfast.</p> <p>LPN #3 was also present at the Nurse's Station at that time, and tried to help the resident make the phone call, but RN #1 would not allow it.</p> <p>Interview with RN #1 on 9/26/13 at</p>	F000174	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct the deficient practice. The nurse involved was educated on F174 and the resident's right to use the telephone. This occurred on 9/24/2013</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents in the facility at this time have the potential to be affected by the alleged deficient practice. All residents present at the resident council on 10/09/2013 were instructed on their right to use a telephone at any time. All other residents were notified in writing of their right to use a telephone.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A policy was developed on 10/8/2013 regarding the resident use of telephone and all staff was inserviced on the policy on 10/8/2013 and 10/15/2013.</p> <p>4. How will corrective actions will be monitored to ensure the deficient practice will not recur? During</p>	10/27/2013			

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	<p>6:40 a.m., indicated on Monday 9/23/13 she was overheard, regarding the use of the telephone with Resident #24. The RN indicated "Yes that was with (Resident name) wanting to use the telephone." The RN was asked why she would not let the resident use the telephone. RN #1 indicated because during that time (in the morning) we were usually busy using the telephone and calling Physicians. At that time, there were two desk phones and one cordless phone sitting on the desk at the Nurse's station. The RN was then asked how many phone lines the facility had, she indicated there was more than one telephone line.</p> <p>The record for Resident #24 was reviewed 9/26/13 at 9:41 a.m.</p> <p>Review of the 9/4/13 quarterly Minimum Data Set (MDS) assessment indicated the resident's Brief Interview for Mental Status (BIMS) score was a 10, indicating the resident was alert and oriented.</p> <p>Interview with the Interim Director of Nursing on 9/26/13 at 10:00 a.m., indicated RN #1 should have allowed the resident to use the telephone at her request.</p>		<p>Resident council the policy will be reviewed and resident will be interviewed to ensure the alleged deficient practice does not recur. This will be done for two months then quarterly thereafter. This will be monitored by the Quality Assurance committee and the Health Facility Administrator. This will be complete on 10/27/2013 Attachment #3 #4</p>	

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	3.1-3(f)			

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure each resident had the choice to choose how many times a week they wish to take a shower for 1 of 3 residents reviewed for choices of the 6 residents who met the criteria for choices. (Resident #41)</p> <p>Findings include:</p> <p>Interview with Resident #41 on 9/23/2013 at 2:15 p.m., indicated she takes a shower one time a week. The resident further indicated she would like to take more than just one shower a week.</p> <p>The record for Resident #41 was reviewed on 9/25/13 at 11:21 a.m. The resident was admitted to the facility on 8/8/13 and then was discharged back to the hospital on 8/15/13. The resident returned back to the facility on 8/17/13.</p>	F000242	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct the alleged deficient practice resident discharged home. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All residents have the potential to be affected by the alleged deficient practice. All residents were told in writing their right to make choices regarding their bath on 10/15/2013 3. What measures will be put into place or what systemic changes will be made to ensure that he deficient practice does not recur. A policy informing the residents their choice of bathing times and frequency was completed on 10/15/2013. All nursing staff was inserviced on 10/08/2013 and 10/15/2013. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur. A random group of (3) Residents will be interviewed monthly to ensure</p>	10/27/2013			

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	<p>Review of the Activity assessment dated 8/9/13 indicated it was very important for the resident to choose between a shower, tub bath and bed bath.</p> <p>Review of the Admission 8/24/13 Minimum Data Set (MDS) assessment indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident needed extensive assist with two person physical assist for bathing.</p> <p>Review of the Shower Schedule indicated the resident was to receive a shower on Monday and Thursday during the day.</p> <p>Review of the completed Shower Sheets indicated the resident had had a shower on 9/5/13, and 9/9/13. The resident refused a shower on 9/19/13. There were only three documented days in the month of September the resident had been given a shower.</p> <p>Review of the August 2013 Shower Sheets, indicated there was no evidence of any shower sheets completed or if the resident had a shower in the month of August. There was no documentation the resident had refused a shower in the</p>		that their right to choose is being honored. This interview will be conducted monthly and overseen by the quality assurance committee and the Health facility Administrator. Completion 10/27/2013 Attachment #5 and#6		

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	<p>month of August.</p> <p>Interview with CNA #1 on 9/25/13 at 2:15 p.m., indicated it was the facility's protocol to fill out the Shower Sheet and give it to the nurse to sign for the skin assessment. He further indicated when the resident refuses a shower he was to fill out the paper and write on the sheet refused. He indicated he had only given the resident one shower since she had been here.</p> <p>Interview with the MDS Coordinator on 9/25/13 at 2:35 p.m., indicated there were no shower sheets for the resident in the month of August. She further indicated she had pulled every sheet that was in the book from last month. She further indicated the facility had not really asked the new residents how many times a week they would like to take a shower.</p> <p>3.1-3(u)(3)</p>						

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review, and interview the facility failed to ensure a call light was within reach for 1 of 30 residents observed for call lights positioned within reach. (Resident #47)</p> <p>Findings include:</p> <p>On 9/13/13 at 10:16 a.m., the Resident #47 was observed in her room seated in her wheelchair. The call light was observed hanging between her night stand and the night stand of her roommate. At that time the resident was asked if she knew where her call light was placed and she indicated, it may be on the floor and requested it be placed within her reach on the bed near her wheelchair.</p> <p>On 9/26/13 at 1:45 p.m., the resident was observed in her room seated in her wheelchair. The call light was not within reach, it was observed lying in the middle of the bed.</p>	F000246	<p>F246 1. What corrective actions will be accomplished for those residents found to be affected by the alleged deficient practice? Resident identified call light was replaced with a pad call light making it easier for her to utilize. This was completed on 10/11/2013 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. Rounds were made on 9/27/2013 to ensure all residents had access to their call light. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A policy was developed on reasonable accommodation of needs. The staff was inserviced on 10/08/2013 and 10/15/2013. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur. A accommodation of need audit will be conducted on (3) random resident rooms biweekly for one</p>	10/27/2013			

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	<p>On 9/26/13 at 1:20 p.m., the resident was observed in bed lying on top of her call light. The resident was asked at this time if she knew where her call light was placed and she indicated she did not know. The call light was observed underneath the resident.</p> <p>Interview with CNA #1 on 9/27/13 at 1:30 p.m., indicated the resident has used the call light in the past. He also indicated he has shown the resident how to use her call light and has reminded her to use it if she needed anything.</p> <p>Interview with the Restorative CNA on 9/27/13 at 1:37 p.m., indicated the resident was capable of using the call light and she used the light more often during the night than during the day. She also indicated she places the call light within the resident's reach when she returns her to her room after therapy sessions.</p> <p>The record for Resident # 47 was reviewed on 9/27/13 at 10:41 a.m. The resident's diagnoses included, but were not limited to, multiple sclerosis, coagulation defects, kidney and ureter disorder, urinary retention, suprapubic catheter, and neurogenic bladder.</p>		<p>month and then monthly thereafter. This will be overseen by the quality assurance director and the Health Facility Administrator. Completion 1/27/2013 Attachment ##7 and #8</p>		

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	<p>Review of Restorative Weekly Progress Note dated 6/30/13, indicated the resident was cognitively intact, had limited range of motion (ROM) to her left arm, and able to feed self.</p> <p>3.1-3(v)(1)</p>				

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F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident's plan of care and/or Physician's Orders were followed related to non pressure related area such as bruising for 2 of 3 residents reviewed for non pressure related areas of the 7 who met the criteria for non pressure related areas and for Unnecessary Medications related to the lack of monitoring Psychotropic Medication and Sliding Scale Insulin for 2 of 5 residents reviewed for Unnecessary Medications. (Residents #22, #35, #41, & #48)</p> <p>Findings include:</p> <p>On 9/23/13 at 9:22 a.m., Resident #35 was observed sitting in her wheelchair. At that time, there was a bruise noted to her left forearm, that was red/purple in color.</p> <p>On 9/24/13 at 2:45 p.m. the resident was observed sitting in her wheelchair. At that time, there was a bruise noted to her left forearm, that</p>	F000282	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Unable to correct the alleged deficient practice on #22, #35, #41, #41. All residents were discharged from facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. An audit of all the residents who receive psychotropic meds was completed on 9/30/2013. An audit was completed on all residents who have sliding scale insulin was audited on 10/03/2013 and skin assessments were completed on all residents on 10/20/2013. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur. All professional nurses were inserviced on Skin assessments, sliding scale insulin and psychotropic medication and behavior monitoring on 10/08/2013 and 10/15/2013. Policy Developed for Medication administration to include glucose monitoring, skin assessments</p>	10/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013
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	<p>was red/purple in color. The resident was wearing short sleeves at the time.</p> <p>On 9/25/13 at 8:33 a.m. and 11:44 a.m., and 1:34 p.m., the resident was observed sitting in her wheelchair. At that time, there was a bruise noted to her left forearm that was red/purple in color. The resident was wearing short sleeves.</p> <p>On 9/26/13 at 12:00 p.m., the resident was observed sitting in her wheelchair. She was wearing short sleeves at the time. Further observation indicated there were two red/purple bruises observed to her left forearm.</p> <p>Interview with LPN #1 on 9/26/13 at 1:00 p.m., indicated he was unaware the resident had any bruises on her arms. He further indicated he was only aware of the one skin tear to her right forearm. LPN #1 indicted he was not given any information regarding any bruises to her left forearm from the previous shift.</p> <p>On 9/26/13 at 1:22 p.m., the Interim Director of Nursing performed a skin assessment of the resident's arms. At that time, she noted two red/purple bruises to the resident's left forearm.</p>		<p>and bruise monitoring and psychotropic medication and behavior monitoring.4. How the corrective actions will be monitored to ensure the alleged deficient practice does not recur. An audit will be conducted on services provided by qualified persons and careplans. This audit will be conducted biweekly on (3) residents for one month and monthly thereafter by the Director of nursing or her representative. This will be overseen by the Quality Assurance committee and the Health Facility Administrator. Attachments #9 #10 #11#12#13</p>		

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	<p>She indicated she was unaware the resident had any bruising to her arms.</p> <p>The record for Resident #35 was reviewed on 9/26/13 at 2:10 p.m. The resident's diagnoses included, but were not limited to Alzheimer disease, congestive heart failure, diabetes type two, and high blood pressure.</p> <p>Review of the updated 7/11/13 plan of care indicated the resident was at risk for abnormal bleeding or hemorrhage because of the use of Aspirin and Hypercoaguable factor V Lesion (a blood disorder). The Nursing approaches were to monitor for and report to the nurse any of the following signs and symptoms of bleeding: unusual bruising.</p> <p>Interview with the MDS Coordinator on 9/27/13 at 8:35 a.m., indicated the expectations for Nursing staff were to assess, measure and monitor the bruising until they were dissolved. She further indicated the Nurses were to record the information on the skin condition sheet and check non pressure areas.</p> <p>2. On 9/23/13 at 2:39 p.m., Resident #41 was observed lying in bed. At that time, the resident was noted to have a red/purple bruise noted on the</p>				

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	<p>right forearm and red/purple bruises noted on left forearm.</p> <p>On 9/24/13 at 2:46 p.m., the resident was observed lying in bed. At that time, the resident was noted to have a red/purple bruise noted on the right forearm and red/purple bruises noted on left forearm.</p> <p>9/25/13 at 9:00 a.m., the resident was observed lying in bed. At that time, the resident was noted to have a red/purple bruise noted on the right forearm and red/purple bruises noted on left forearm.</p> <p>On 9/25/13 at 1:56 p.m., LPN #1 was observed during a skin assessment of the resident's arms. At that time the resident's sleeve was raised. There was a large blue/purple bruise to her right upper arm, a small bruise red/purple bruise to the right forearm and two bruises to the left forearm that were red/purple in color. The LPN indicated he was not aware she had the bruises to her arms.</p> <p>The record for Resident #41 was reviewed on 9/25/13 at 11:21 a.m. The resident was admitted to the facility on 8/8/13 from the hospital. The resident's diagnoses included, but were not limited to, high blood</p>						

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	<p>pressure, coronary artery disease, thyroid disease, mitral valve regurgitation, diabetes type two, anemia, deep vein thrombosis, congestive heart failure, and chronic macrocytic anemia.</p> <p>Review of the current 8/2013 plan of care plan indicated the problem of impaired skin integrity: resident has disruption of skin surface not related to pressure, bruise noted to left deltoid, left buttock, and right thigh. The Nursing approaches were to complete weekly skin assessments, and inspect skin during bathing.</p> <p>Interview with the MDS Coordinator on 9/27/13 at 8:35 a.m., indicated the expectations for Nursing staff were to assess, measure and monitor the bruising until they were dissolved. She further indicated the Nurses were to record the information on the skin condition sheet and check non pressure areas.</p> <p>3. The record for Resident #48 on 9/24/13 at 1:05 p.m. Diagnoses included, but were not limited to, gunshot wound, brain dysfunction, hypertension, diabetes, depression,</p>						

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	<p>acute kidney failure, stroke/late effect, and anxiety.</p> <p>Review of the Medication Administration Record (MAR) dated 9/13, indicated an order for Paxil (antidepressant) 10 (milligrams) mg twice a day, Seroquel (antipsychotic)100 mg daily, Effexor-XR (antidepressant)150 mg daily, and Xanax (antianxiety) 1 mg as needed every four hours.</p> <p>Review of the Nursing Notes dated 9/10/13, indicated orders were received to begin scheduled Xanax three times a day. The resident was assessed for anxiety dated 9/10/13 thru 9/13/13. There was no evidence of daily documentation of behaviors on any other dates noted thru 9/25/13.</p> <p>Review of the Interim Admission Care Plan dated 9/6/13, indicated monitor for effectiveness of psychotropic medications.</p> <p>Review of the Behavior/Intervention Monthly Flow Records dated 9/13, indicated no evidence of documentation for behaviors.</p> <p>Interview with the MDS Coordinator on 9/24/13 at 1:40 p.m., indicated</p>			

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	<p>when residents were ordered psychotropic medications it is the responsibility of the Social Services Director to initiate behavior sheets and place them into the MAR in front of the Physician's Orders.</p> <p>Interview with the Social Services Director on 9/24/13 at 1:44 p.m., indicated the resident was not being monitored for behaviors in accordance with the Care Plan due to the lack of a behavior flow sheet being created and placed into the resident's MAR.</p> <p>4. The record for Resident #22 was reviewed on 9/24/13 at 1:14 p.m. The resident's diagnoses included, but were not limited to, type II diabetes mellitus, hypertension, and anemia.</p> <p>Review of the Physician Recapitulation Orders dated September 2013, indicated an order for sliding scale (insulin given per blood glucose test result) Novolog (insulin) twice daily, with the following doses: < (less than) 60= Call MD (Physician) 0-150=0 units 151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units</p>						

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	<p>351-400=10 units > (greater than) 400=Call MD</p> <p>The Medication Administration Record (MAR) dated August 2013, indicated there were no blood glucose test results recorded for the 7 a.m. blood glucose test on 8/1/13, 8/2/13, 8/3/13, 8/4/13, 8/5/13, 8/6/13, 8/7/13, 8/9/13, 8/10/13, and 8/11/13. There was no blood glucose test result recorded for the 5 p.m. blood glucose test on 8/31/13. The resident's blood glucose test result on 8/13/13 at 5 p.m. was 171 and no insulin was given.</p> <p>The MAR dated August 2013, indicated the resident's blood sugar on 8/31/13 at 7 a.m. was 47. There was no indication on the MAR indicating the MD was notified. Review of the Nursing Notes dated 8/31/13 lacked documentation that the MD was notified of the low blood sugar.</p> <p>The MAR dated September 2013 indicated there was no blood glucose test result recorded for the 5 p.m. blood glucose test on 9/3/13. The resident's blood glucose test result on 9/10/13 at 5 p.m. was 159 and no insulin was given, the resident's blood glucose test result on 9/15/13 at 5</p>				

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	<p>p.m. was 237 and no insulin was given.</p> <p>Review of the current plan of care updated on 7/1/13 indicated the resident was at risk for complications associated with hyper or hypoglycemia related to diabetes mellitus. The Nursing interventions included: administer insulin as ordered, perform Accuchecks (blood glucose test) as ordered, and notify MD if BS (blood sugar) is <60 or >400.</p> <p>Interview with the Interim Director of Nursing on 9/26/13 at 10:55 a.m., indicated Accucheck results should have been documented on the MAR, insulin should have been given according to the sliding scale, and sliding scale insulin doses should have been documented on the MAR. She indicated the MD should have been notified of the low blood sugar according to order parameters. She indicated Accucheck results and sliding scale insulin doses administered may have been documented on the 24 hour report but was unable to find documentation to support this. She indicated she was also unable to find documentation that the MD was notified of the resident's low blood sugar on 8/31/13.</p>			

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013	
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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure non pressure related areas related to bruising were assessed, monitored, and measured until they were resolved for 3 of 3 residents reviewed for non pressure related areas of the 7 who met the criteria for non pressure related areas. (Residents #15, #35, #41)</p> <p>Findings include:</p> <p>1. On 9/23/13 at 9:22 a.m., Resident #35 was observed sitting in her wheelchair. At that time, there was a bruise noted to her left forearm, that was red/purple in color.</p> <p>On 9/24/13 at 2:45 p.m. the resident was observed sitting in her wheelchair. At that time, there was a bruise noted to her left forearm, that was red/purple in color. The resident was wearing short sleeves at the time.</p>	F000309	<p>F309 1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Unable to correct on patient #35, #41 as they were discharged. Resident #15 skin was assessed and non-pressure sheets were updated. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. Skin assessments have been completed on all residents on 10/20/2013. What measures have been put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Policy and procedure on documentation of bruises and MD and family notification was revised. All nursing staff was inserviced on care and services for highest wellbeing on 10/08/2013 and 10/15/2013. 4. How the corrective actions will be monitored to ensure the deficient</p>	10/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013
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	<p>On 9/25/13 at 8:33 a.m. and 11:44 a.m., and 1:34 p.m., the resident was observed sitting in her wheelchair. At that time, there was a bruise noted to her left forearm that was red/purple in color. The resident was wearing short sleeves.</p> <p>On 9/26/13 at 12:00 p.m., the resident was observed sitting in her wheelchair. She was wearing short sleeves at the time. Further observation indicated there were two red/purple bruises observed to left forearm.</p> <p>Interview with LPN #1 on 9/26/13 at 1:00 p.m., indicated he was unaware the resident had any bruises on her arms. He further indicated he was only aware of the one skin tear to her right forearm. LPN #1 indicted he was not given any information regarding any bruises to her left forearm from the previous shift.</p> <p>On 9/26/13 at 1:22 p.m., the Interim Director of Nursing performed a skin assessment of the resident's arms. At that time, she noted two red/purple bruises to the resident's left forearm. She indicated she was unaware the resident had any bruising to her arms.</p> <p>The record for Resident #35 was</p>		<p>practice will not recur. An audit of Care and services for highest wellbeing will be conducted biweekly for one month on (3) residents by the Director of nursing or her representative and monthly thereafter. This will be overseen by the Quality assurance committee and the Health Facility Administrator. Completion 10/27/2013Attachments #12#13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013
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	<p>reviewed on 9/26/13 at 2:10 p.m. The resident's diagnoses included, but were not limited to Alzheimer disease, congestive heart failure, diabetes type two, and high blood pressure.</p> <p>Review of the 7/11/13 quarterly Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented and she was an extensive assist with one person physical assist with transfers and bed mobility.</p> <p>Review of the updated 7/11/13 plan of care indicated the resident was at risk for abnormal bleeding or hemorrhage because of the use of Aspirin and Hypercoaguable factor V Lesion (a blood disorder). The Nursing approaches were to monitor for and report to the nurse any of the following signs and symptoms of bleeding: unusual bruising.</p> <p>Review of Physician Orders on the current 9/13 recap indicated an order dated 1/29/13 for Aspirin 81 milligrams (mg) daily.</p> <p>Review of Nursing Progress Notes for the month 9/13 up until 9/26/13 indicated there was no evidence of any documentation of any bruising to the resident's left forearm.</p>				

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	<p>Review of the non pressure skin sheet indicated there was no sheets completed for the bruises to the left forearm.</p> <p>Review Nursing Progress Notes dated 9/26/13 at 1:00 p.m., upon assessment writer observed two discolorations to the left forearm measuring .8 centimeters (cm) by 1 cm purple in color and .4 cm by .5 cm purple in color.</p> <p>Interview with the MDS Coordinator on 9/27/13 at 8:35 a.m., indicated the expectations for Nursing staff were to assess, measure and monitor the bruising until they were dissolved. She further indicated the Nurses were to record the information on the skin condition sheet and check non pressure areas.</p> <p>2. On 9/23/13 at 2:39 p.m., Resident #41 was observed lying in bed. At that time, the resident was noted to have a red/purple bruise noted on the right forearm and red/purple bruises noted on left forearm.</p> <p>On 9/24/13 at 2:46 p.m., the resident was observed lying in bed. At that time, the resident was noted to have a red/purple bruise noted on the right</p>			

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	<p>forearm and red/purple bruises noted on left forearm.</p> <p>9/25/13 at 9:00 a.m., the resident was observed lying in bed. At that time, the resident was noted to have a red/purple bruise noted on the right forearm and red/purple bruises noted on left forearm.</p> <p>On 9/25/13 at 1:56 p.m., LPN #1 was observed during a skin assessment of the resident's arms. At that time the resident's sleeve was raised. There was a large blue/purple bruise to her right upper arm, a small bruise red/purple bruise to the right forearm and two bruises to the left forearm that were red/purple in color. The LPN indicated he was not aware she had the bruises to her arms.</p> <p>The record for Resident #41 was reviewed on 9/25/13 at 11:21 a.m. The resident was admitted to the facility on 8/8/13 from the hospital. The resident's diagnoses included, but were not limited to, high blood pressure, coronary artery disease, thyroid disease, mitral valve regurgitation, diabetes type two, anemia, deep vein thrombosis, congestive heart failure, and chronic macrocytic anemia.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2013
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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	<p>Physician Orders on the current recap dated 9/13 indicated an order for Coumadin (a medication used to thin the blood) 4 milligrams (mg) daily.</p> <p>Review of the 8/24/13 admission Minimum Data Set (MDS) assessment indicated the resident was alert and oriented and was receiving anticoagulant therapy 7 days a week.</p> <p>Review of the non pressure ulcer sheets indicated there were no sheets for the resident bruises to her arms.</p> <p>Review of Nursing Progress Notes for September 2013 indicated there was no evidence of any documentation or assessment of any bruising to her right upper and lower forearm, and left forearm.</p> <p>On 9/25/13 at 2:45 p.m., LPN #1 measured and assessed the bruises to the resident's arms. The left forearm bruise measured 2.5 centimeters (cm) by 2 cm. The right forearm bruise measured .5 cm by .5 cm and the left posterior arm bruise measured 1.2 cm by 2.5 cm.</p> <p>Interview with the MDS Coordinator on 9/27/13 at 8:35 a.m., indicated the expectations for Nursing staff were to</p>			

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
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	<p>assess, measure and monitor the bruising until they were dissolved. She further indicated the Nurses were to record the information on the skin condition sheet and check non pressure areas.</p> <p>3. On 9/23/13 at 3:17 p.m., Resident # 15 was observed seated in his wheelchair in his room. He was observed to have multiple small bruises on the top of his left hand and forearm.</p> <p>Record review on 9/25/13 at 11:18 a.m., indicated the resident's diagnoses included, but were not limited to, falls, abnormal gait, adult failure to thrive, high blood pressure, and diabetes.</p> <p>Review of the Treatment Administration Record (TAR) indicated there was no evidence of documentation of the resident being monitored for bruising.</p> <p>Review of the Non-Pressure Skin Sheets indicated there was no evidence of documentation of the resident having any non-pressure skin related issues.</p> <p>Review of the CNA shower sheets</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
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	<p>dated 9/25/13, indicated there was no bruising to resident's left hand or forearm.</p> <p>Interview with LPN #1 on 9/25/13 at 11:20 p.m., indicated the resident was not being monitored for non-pressure skin issues such as bruising.</p> <p>Interview with the MDS Coordinator on 9/25/13 at 2:46 p.m., indicated skin assessments were completed with each shower and new skin related issues were to be documented on the CNA shower sheets by the nursing staff. She also indicated if a new area was found, the nurse would then document the measurements on a wound sheet and monitor it until healed every 7 days.</p> <p>Interview with LPN #1 on 9/26/13 at 11:06 a.m., indicated the residents were assessed on shower days, per Physician's Orders, after they returned from off site visits, and during change in condition. The LPN further indicated there was no documentation or assessment of the bruises on the top of the resident's left hand or forearm.</p> <p>3.1-37(a)</p>				

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interviews the facility failed to ensure the hot water temperatures in the resident's rooms were between 100 and 120 degrees Fahrenheit for 1 of 1 Units. This had the potential to affect 8 of 34 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. On 9/23/13 at 2:50 p.m., the hot water was hot to touch in room 7. At that time, a temperature of the hot water was obtained in which it was 123 degrees Fahrenheit. There were two residents who resided in this room.</p> <p>On 9/23/13 at 3:09 p.m., the hot water was hot to touch in room 8. At that time, a temperature of the hot water was obtained in which it was 122.5 degrees Fahrenheit. There were two residents who resided in this room.</p> <p>On 9/23/13 at 3:10 p.m., the hot water was hot to touch in room 9. At that time, a temperature of the hot water</p>	F000323	F323 1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Unable to correct the alleged deficient practice on rooms 7,8,9,10. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents on the middle and back hall have the potential to be affected by the alleged deficient practice. The hot water heater was turned down on September 23, 2013. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The water temperate policy was revised on 10/15/2013 to include random times of temperature checks. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur? Water temps will be conducted weekly on five rooms at random times. This will be overseen by the Quality Assurance Committee and the Health Facility Administrator. Completion	10/27/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
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	<p>was obtained in which it was 123 degrees Fahrenheit. There were two residents who resided in this room.</p> <p>On 9/23/13 at 3:12 p.m., the hot water was hot to touch in room 10. At that time, a temperature of the hot water was obtained in which it was 121.5 degrees Fahrenheit. There were two residents who resided in this room.</p> <p>On 9/23/13 at 2:54 p.m., the Environmental Supervisor obtained a hot water temperature from room 7 in which he obtained a reading of 118, and when rechecked after 15 seconds the temperature was then 127.1.</p> <p>On 9/23/13 at 3:20 p.m., the water temperatures in the above mentioned rooms were below 120 degrees Fahrenheit.</p> <p>On 9/23/13 at 5:00 p.m. the Weekly Water Temperature Log dated 8/26/13 to 9/16/13 was reviewed. The log indicated all water temperatures were below 120 degrees Fahrenheit.</p> <p>On 9/23/13 at 3:30 p.m. the Environmental Supervisor indicated the water temperatures were checked every Monday at 5:00 a.m.</p>		10/27/2013.Attachments #14 #15		

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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	<p>On 9/27/13 at 9:50 a.m., during the Environmental Tour the hot water temperature in the above mentioned rooms were less than 120 degrees Fahrenheit.</p> <p>3.1-19(r)(1) 3.1-19(r)(2)</p>			

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to ensure each resident was free from unnecessary medications related to the monitoring of psychotropic medications and sliding scale insulin and ensuring there was an adequate indication for the use of an antipsychotic medication for 2 of 5 residents reviewed for unnecessary medication. (Resident # 22 and #48)</p> <p>Findings include:</p>	F000329	F329 1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Unable to correct the alleged deficient practice. Resident #22 and #48 were discharged. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Diabetic residents and residents receiving psychotropic medications have the potential to be affected by the alleged	10/27/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013	
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322			
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	<p>1. The record for Resident #48 was reviewed on 9/24/13 at 1:05 p.m. The diagnoses included but were not limited to, gunshot wound, brain dysfunction, hypertension, diabetes, depression, acute kidney failure, stroke/late effect, and anxiety.</p> <p>Review of the Medication Administration Record (MAR) dated 9/13, indicated an order for Paxil (antidepressant) 10 milligrams (mg) twice a day, Seroquel (antipsychotic)100 mg daily, Effexor-XR (antidepressant)150 mg daily, and Xanax (antianxiety) 1 mg as needed every four hours. Further review of the MAR indicated diagnoses for the above medications except for Seroquel.</p> <p>Review of the Nursing Notes dated 9/10/13, indicated orders were received to begin scheduled Xanax three times a day.</p> <p>Review of the Interim Admission Care Plan dated 9/6/13, indicated monitor for effectiveness of psychotropic medications.</p> <p>Review of the Behavior/Intervention Monthly Flow Records dated 9/13, indicated no evidence of</p>		<p>deficient practice. An audit of all residents receiving psychotropic medication and sliding scale insulin was completed on 10/1/2013 and corrections made.</p> <p>3. What measures have been put in place or what systemic changes will be made to ensure that the deficient practice does not recur? A policy was developed on Drug regimen is free from unnecessary drugs on 10/08/2013. A policy was developed on medication administration including glucose monitoring All professional nurses were inserviced on 1/8/2013 and 10/15/2013. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur? An audit will be conducted biweekly for one month on (3) residents by the Director of Nursing or her representative. then monthly thereafter. Oversight will be conducted by the Quality Assurance committee and the Health Facility Administrator.</p> <p>Completion 10/27/2013 Attachments #9 #10 #11</p>				

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
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	<p>documentation for behaviors.</p> <p>Interview with the MDS Coordinator on 9/24/13 at 1:40 p.m., indicated when residents are ordered psychotropic medications it is the responsibility of the Social Services Director to initiate behavior sheets and place them into the MAR in front of the Physician's Orders. She also indicated there was no proper diagnosis for the use of the Seroquel medication.</p> <p>Interview with the Social Services Director on 9/24/13 at 1:44 p.m., indicated the resident was not being monitored for behaviors in accordance with the Care Plan due to the lack of a behavioral flow sheet being created and placed into the resident's MAR. She also indicated there was no proper diagnosis for the use of the Seroquel medication.</p> <p>2. The record for Resident #22 was reviewed on 9/24/13 at 1:14 p.m. The resident's diagnoses included, but were not limited to, type II diabetes mellitus, hypertension, and anemia.</p> <p>Review of the Physician Recapitulation Orders dated September 2013, indicated an order for sliding scale (insulin given per blood glucose test result) Novolog</p>				

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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	<p>(insulin) twice daily, with the following doses: < (less than) 60= Call MD (physician) 0-150=0 units 151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units > (greater than) 400=Call MD</p> <p>The Medication Administration Record (MAR) dated August 2013, indicated there were no blood glucose test results recorded for the 7 a.m. blood glucose test on 8/1/13, 8/2/13, 8/3/13, 8/4/13, 8/5/13, 8/6/13, 8/7/13, 8/9/13, 8/10/13, and 8/11/13. There was no blood glucose test result recorded for the 5 p.m. blood glucose test on 8/31/13. The resident's blood glucose test result on 8/13/13 at 5 p.m. was 171 and no insulin was given.</p> <p>The MAR dated August 2013, indicated the resident's blood sugar on 8/31/13 at 7 a.m. was 47. There was no indication on the MAR indicating the MD was notified. Review of the Nursing Notes dated 8/31/13 lacked documentation that the MD was notified of the low blood sugar.</p>			

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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	<p>The MAR dated September 2013 indicated there was no blood glucose test result recorded for the 5 p.m. blood glucose test on 9/3/13. The resident's blood glucose test result on 9/10/13 at 5 p.m. was 159 and no insulin was given, the resident's blood glucose test result on 9/15/13 at 5 p.m. was 237 and no insulin was given.</p> <p>Interview with the Interim Director of Nursing on 9/26/13 at 10:55 a.m., indicated Accucheck results should have been documented on the MAR, insulin should have been given according to the sliding scale, and sliding scale insulin doses should have been documented on the MAR. She indicated the MD should have been notified of the low blood sugar according to order parameters. She indicated Accucheck results and sliding scale insulin doses administered may have been documented on the 24 hour report but was unable to find documentation to support this. She indicated she was also unable to find documentation that the MD was notified of the resident's low blood sugar on 8/31/13.</p> <p>3.1-48(a)(6)</p>			

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5% was maintained for 2 of 6 residents observed during medication pass. Two errors were observed during 30 opportunities for error during medication administration. This resulted in a medication error rate of 6.6%. (Resident #9 & #30).</p> <p>Findings include:</p> <p>1. On 9/25/13 at 8:57 a.m., LPN #2 was observed preparing medication for Resident #9. At that time, she pulled an inhaler out of the drawer to administer to the resident. The inhaler was Flovent HFA to administer two puffs by mouth twice a day. The LPN proceeded to enter the resident's room and applied clean gloves to both of her hands. She then shook the inhaler first and then gave one puff to the resident and instructed the resident to breathe in. The LPN waited five seconds and gave the resident the second puff. The LPN did not wait a full minute in between puffs, nor did she shake the container</p>	F000332	<p>F332 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct the alleged deficient practice. Resident #9 was assessed and no adverse reactions noted and Resident #30 also was assessed with no adverse reactions and orders clarified to administer one hour before meals. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Residents receiving Prilosec and Inhaled medication have the potential to be affected by the alleged deficient practice. Prilosec Orders were written to administer according to guidelines for those receiving Prilosec on 10/15/2013. The nurse involved was educated on waiting the one minute before administering inhaled medications. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A policy on medication administration was obtained regarding inhaled medications and Prilosec. The professional nurses and qma</p>	10/27/2013

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322			
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	<p>before administrating the second inhalation. After, the second puff, the resident started to cough and had a hard time catching her breath, the nurse stayed with the resident until she was stable.</p> <p>The record for Resident #9 was reviewed on 9/27/13 at 9:45 a.m. Review of Physician Orders dated 4/25/13 indicated Flovent 110 Micrograms (MCG) HFA inhale two puffs by mouth twice a day.</p> <p>Review of the current and undated Specific Medication Administration Procedures: Oral Inhalation Administration provided by the Interim Director of Nursing indicated "Wait one minute between puffs for multiple inhalations of the same medication.</p> <p>Interview with LPN #2 on 9/25/13 at 9:00 a.m., indicated she had thought she waited a full minute in between the puffs. The LPN further indicated she knew she was supposed to wait three minutes in between puffs with different inhalers and one minute between puffs with the same inhaler.</p> <p>Interview with Interim Director of Nursing on 9/27/13 at 10:10 a.m., indicated the nurse should have waited a full minute in between the</p>		<p>were inserviced on 10/08/2013.</p> <p>4. How the corrective actions will be monitored to ensure the deficient practice will not recur. A Medication Administration audit was developed to include Prilosec and inhaled medications. An audit will be completed biweekly for one month and monthly thereafter. This will be monitored by the Quality Assurance committee and the Health Facility Administrator. Completion 10/27/2013 attachments #16#17</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013	
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322			
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	<p>inhalations of the Flovent inhaler.</p> <p>2. On 9/25/13 at 9:17 a.m., LPN #1 was observed preparing medication for Resident #30. At that time, he poured the medication of Omeprazole (Prilosec) 20 milligrams (mg) into the medication cup. He then took the medications into the resident's room and administered the pills to the resident.</p> <p>Interview with LPN #1 at that time, indicated the resident had already eaten breakfast earlier in the morning.</p> <p>The record for Resident #30 was reviewed on 9/27/13 at 9:35 a.m. Review of Physician Orders on the current recap indicated Omeprazole 20 milligrams (mg) by mouth daily at 8:00 a.m.</p> <p>Review of the Prilosec instructions indicated the medication should be administered at least one hour before meals.</p> <p>Interview with the Interim Director of Nursing on 9/27/13 at 10:10 a.m., indicated she was unaware the Omeprazole should have been given before the meals.</p> <p>3.1-25(b)(9)</p>						

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2013
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Nurse Staff sign was posted with the correct information and at least 18 months of the Nurse Staff information was kept on file for 1</p>	F000356	F356 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. 2. How other residents having the	10/27/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013	
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322			
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	<p>of 1 Nurse Staff signs.</p> <p>Findings include:</p> <p>On 9/25/13 at 8:24 a.m. the staffing sign was posted on the wall. The sign consisted of the names of the department heads and their phone numbers and the staff names of who was working in the facility. The sign did not have the facility name on the top of the page.</p> <p>Review of the last three months of the Nurse Staff information that was posted indicated for the months of 7/13 and 8/13 the facility's name was posted on the sheets, however, for the month of 9/13 there was no facility name on the sheets.</p> <p>Further review of the old Nurse Staff information indicated there was no evidence of 18 months worth of daily nurse staffing sheets available for review.</p> <p>Interview with the MDS Coordinator on 9/26/13 at 9:00 a.m., indicated she was only able to find the last three months of nurse staffing signs. She further indicated it has been her job just recently to post the signs everyday and to save the old staffing sheets.</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? No residents were affected by the alleged deficient practice. The form was corrected on 10/15/2013 to include the name of the facility. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A policy was developed regarding the posting of staffing. Management staff inserviced on 10/15/2013 regarding posting of staffing. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur. An audit will be conducted weekly for one month and monthly thereafter to ensure that the forms include the name of facility and retained for 18 months. This will be overseen by the Quality assurance committee and the Health Facility Administrator. Completion 10/27/2013 Attachments #18 19</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
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	3.1-13(a)				

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
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F000364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to serve food at a warm temperature for 1 of 2 meals observed. (The Breakfast meal)</p> <p>Findings include:</p> <p>On 9/26/13 at 7:20 a.m., the first cart of breakfast trays came out into the dining room. At 7:31 a.m., the second cart of breakfast trays came out of the kitchen. At that time, some of the trays were passed to the resident's in the Main Dining Room and the other trays were room trays.</p> <p>The Maintenance Supervisor was observed passing the resident's room breakfast trays. The last tray was passed at 7:43 a.m. At that time, temperatures were taken of the test tray that was placed on the cart. The hot cereal was 146 degrees Fahrenheit, the sausage links was 132 degrees, and the pancakes were 90 degrees.</p> <p>Interview with a Confidential, alert,</p>	F000364	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? We were unable to correct the alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents who get room trays have the potential to be affected by the alleged deficient practice. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A policy will be developed on 10/15/2013 regarding food temperatures. All staff was inserviced on 10/08/2013 and 10/15/2013 regarding the passing of room trays. 4. An audit will be performed to ensure food on resident trays is at palatable temperature. This audit will be conducted daily for one week on two random meals per day by the cook. this will be weekly for four weeks and monthly thereafter. This will be monitored by the Quality assurance committee and the Health Facility Administrator.</p>	10/27/2013	

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	<p>and oriented resident on 9/23/13 at 9:35 a.m., indicated the resident eats most of her meals in her room. She further indicated the food was served cold and it was for all the meals.</p> <p>Interview with a Confidential, alert, and oriented resident on 9/23/13 3:43 p.m., indicated the food was too cold, usually all meals. The food was always cold for room trays when she ate in her room.</p> <p>Interview with the Dietary Food Manager at 7:45 a.m., on 9/26/13 indicated the pancakes, sausage and hot cereal were temped before they left the kitchen in which all were above 140 degrees Fahrenheit. She further indicated she has one electric food warmer in which the pancakes were in. She indicated the sausage was being kept in the oven and the hot cereal was on the stove. The Dietary Food Manager indicated the facility does not have a steam table to keep the food hot. She further indicated they use the pallets and the lids to keep the food warm, but they were not heated pallets. She further indicated the pancakes should have been served at a warmer temperature.</p> <p>3.1-21(a)(2)</p>		<p>Completion 10/27/2013 Attachments # 20 #21</p>		

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to serve beverages under sanitary conditions related to uncovered cups of juice, coffee, and milk that were transported down the hallway to resident rooms. This had the potential to effect the 34 residents who resided in the facility.</p> <p>Findings include:</p> <p>On 9/23/13 at 8:00 a.m. during Orientation Tour there were four breakfast trays on a tall transportation cart. At that time, the juice glasses on the trays were not covered.</p> <p>On 9/26/13 at 7:28 a.m. the Maintenance Supervisor was observed walking down the hallway with a breakfast tray in his hand. At that time, there was a cup of coffee, juice and milk on the tray, all were uncovered.</p> <p>On 9/26/13 at 7:29 a.m., the MDS Coordinator was observed walking</p>	F000371	F371 1. What corrective actions will be accomplished for those residents found to be affected by the alleged deficient practice? We were unable to correct the alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents who get room trays may be affected by the alleged deficient practice. Lids were applied to all juice glasses on 10/8/2013 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The policy on Food served in a sanitary manner was developed on 10/08/2013. All nursing staff was inserviced on 10/08/2013 and 10/15/2013. 4. How the corrective actions will be monitored to ensure the deficient practice will not occur. An audit will be completed biweekly on (2) random meals for one month and monthly thereafter monitoring food being prepared in a sanitary manner. This will be monitored by the Quality Assurance Committee and the Health Facility	10/27/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
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	<p>down the hallway with a breakfast tray in her hand. At that time there was a cup of coffee, milk, and juice on the tray, all were uncovered.</p> <p>Interview with the Dietary Food Manager on 9/26/13 at 9:20 a.m., indicated the resident's meal trays were transported out of the kitchen into the hallway for staff to serve them. She further indicated the beverages on the meal trays should be covered when they are transported down the hallway.</p> <p>3.1-21(i)(3)</p>		Administrator.Attachments #21 #22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2013
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Insulin vials were labeled after opening and the disposition of a</p>	F000431	F431 1. What corrective actions will be accomplished for those residents found to be affected by the alleged deficient practice? The patch was disposed of in the	10/27/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322		
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	<p>used Fentanyl patch (a narcotic pain medication) for 2 of 2 medication carts observed and for 1 of 6 residents observed during medication pass. (Resident #17)</p> <p>Findings include:</p> <p>1. On 9/25/13 at 9:10 a.m., LPN #2 was observed preparing medication for Resident #17. At that time, she removed a Fentanyl patch from the narcotic box and was going to place it on the resident's skin. The LPN finished the rest of the resident's medications and walked into the resident's room. LPN #2 then washed her hands with soap and water and applied clean gloves. She then removed the old Fentanyl patch that was on the resident's body and placed it into her gloved hand. She then removed her gloves, rolled them into a ball and threw everything away including the patch into the garbage can by the resident's sink in her room. The LPN finished the medication pass with the resident and left the room.</p> <p>Review of the current and undated Controlled Medication Destruction Policy provided by the Interim Director of Nursing indicated when a dose of a controlled medication was removed from the container for administration</p>		<p>proper container and all vials were dated on 9/26/2013 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Residents who received Fentanyl patches and vials of medications have the potential to be affected. The nurse involved in disposing medication was educated on proper disposal and all vials were dated. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A policy was obtained on storage and disposal of medication. All professional nurses were inserviced on 10/08/2013 and 10/15/2013 on policy. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur. An audit will be conducted on medication storage and disposal weekly for one month then quarterly thereafter. The Quality Assurance Committee will monitor along with the Health Facility Administrator. Completion 10/27/2013 Attachments #23 #24</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013	
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322			
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	<p>but refused by the resident or not given for any reason, it was not placed back in the container. It was destroyed in the presence of two licensed nurses and the disposal was documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason.</p> <p>Interview with the LPN at that time, indicated she was not supposed to throw the patch into the garbage can. She was supposed to dispose the patch into the sharps container that was either located in the resident's room, or on the side of the medication cart.</p> <p>2. Observation of the front hall medication cart on 9/26/13 at 2:00 p.m., indicated there were two multi dose vials/containers that were not labeled with an open date.</p> <p>Observation of the back hall medication cart on 9/26/13 at 2:05 p.m., indicated there was one multi dose vial/container that was not labeled with an open date.</p> <p>Interview with the Executive Director (ED) on 9/26/13 at 2:06 p.m.,</p>						

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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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	<p>indicated either the vial or the container should be labeled with an open date.</p> <p>3.1-25(j)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013	
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F000505 SS=D	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview the facility failed to ensure the resident's Physician was promptly notified of abnormal lab values for 1 of 5 residents reviewed for Unnecessary Medications. (Resident #32)</p> <p>Findings include:</p> <p>The record for Resident #32 was reviewed on 9/24/13 at 1:51 p.m. The resident's diagnoses included, but were not limited to, abnormal gait, muscle weakness, confusion, dementia, anxiety, congenital cerebral palsy, mental retardation, essential tremors, dementia with anxiety and depressive features.</p> <p>Review of Physician Orders dated 7/22/13 indicated Phenobarbital Level on 9/2/13. Further review of Physician Orders dated 9/10/13, indicated Primidone (a medication used for tremors)100 milligrams (mg) in the morning and 50 mg at bedtime.</p> <p>Review of the Phenobarbital lab level that was completed on 9/5/13 indicated the level was low with 4.1</p>	F000505	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The MD was notified of the abnormal lab for the resident #32 new orders were carried out. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents who have had labs drawn may have the potential to be affected by the deficient practice. Labs were reviewed on 10/15/2013. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A policy was developed on notification of physician of abnormal labs. All nursing staff was inserviced on 10/08/2013 and 10/15/2013. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur. An audit of labs will be conducted weekly for four weeks and then monthly thereafter. The Quality Assurance Committee will monitor along with the Health Facility Administrator. Completion 10/27/2013 Attachments #25 #26</p>	10/27/2013			

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	<p>reading. The normal level was 15-40.</p> <p>Review of Nurse's Notes dated 9/10/13 at 6:00 p.m., indicated MD (Physician) aware of Phenobarbital level. New order received for Primidone.</p> <p>Review of the current 4/20/12 Change in Resident's Condition or Status policy provided by the Interim Director of Nursing indicated "The Nurse will notify the resident's attending Physician or on call Physician when there has been: Abnormal lab results that require Physician intervention."</p> <p>Interview with LPN #4 on 9/24/13 at 8:30 p.m., indicated she was the nurse who called the Physician on 9/10/13. She indicated she saw the lab report and notified the doctor, because the Physician had not been made aware. She indicated the policy was to notify the Physician on the same day as the labs were drawn if there was an abnormal value. She further indicated the first time the Physician was made aware of the Phenobarbital level was when she had notified him on 9/10/13 (five days after the lab had been drawn).</p> <p>3.1-49(f)(2)</p>				

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify non-compliance of the facility's non pressure related areas related to the monitoring and assessing of bruises through the quality assurance protocol.</p> <p>Findings include:</p> <p>Interview with the Administrator on 9/27/13 at 1:27 p.m., indicated the</p>	F000520	F520 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents with bruises may have the potential to be affected by the alleged deficient practice. We were unable to correct. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Residents who have bruises may be affected by the alleged deficient	10/27/2013			

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	<p>facility's Quality Assurance Committee meets every month and consists of herself, the Director of Nursing, Social Service, Dietary, Activities, and Nursing as well as the Medical Director. The Administrator indicated at the time, non pressure related areas such as bruising had not been discussed, addressed or identified as being a problem in Quality Assurance. She further indicated there had been no action plan or system put into place to identify the problem of not identifying, assessing, or monitoring bruises.</p> <p>She indicated they had not been aware of there was a problem of not monitoring or assessing new bruises. She further indicated the process/system that was in place to identify changes with the residents was to discuss the issues and talk about the problems in the daily morning meeting. She indicated they (department heads) would discuss any significant changes that had happened to the residents and what interventions needed to be put in place.</p> <p>Interview with the MDS Coordinator on 9/27/13 at 8:35 a.m., indicated the expectations for Nursing staff were to assess, measure and monitor the</p>		<p>practice. Bruises are being monitored in our morning Quality review and is ongoing. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A policy regarding quality assurance and bruises was developed. The quality assurance committee was inserviced on this policy on 10/15/2013, 4. How the corrective actions will be monitored to ensure the deficient practice will not recur. An audit will be conducted monthly. This will be monitored by the Quality Assurance committee and the Health Facility Administrator. Completion 10/27/2013. Attachments #27 #28</p>	

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	bruising until they were dissolved. She further indicated the Nurses were to record the information on the skin condition sheet and check non pressure areas. 3.1-52(b)(2)				